DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAY 19 2004

Report Number: A-04-01-00005

Mrs. Carmen Hooker Odom
Secretary
North Carolina Department of Health
and Human Services
101 Blair Drive, Adams Building
Raleigh, North Carolina 27603

Dear Mrs. Odom:

Enclosed are two copies of a Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled "Audit of Medicaid Fee-for-Service Payments to Local Education Agencies in North Carolina for the Period July 1, 1999 Through June 30, 2000." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determinations as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-04-01-00005 in all correspondence.

Sincerely,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures - as stated

Direct Reply to HHS Action Official:

Mr. Renard Murray
Associate Regional Administrator for Medicaid
Centers for Medicare & Medicaid Services, Region IV
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICAID FEE-FOR-SERVICE PAYMENTS TO LOCAL EDUCATION AGENCIES IN NORTH CAROLINA FOR THE PERIOD JULY 1, 1999 THROUGH JUNE 30, 2000

MAY 2004
A-04-01-00005

EXECUTIVE SUMMARY

OBJECTIVES

Our objectives were to determine whether (1) claims for school-based services were allowable under Federal and State requirements, (2) payment rates were supported and reasonable, and (3) the State share for claiming Federal funding was met.

SUMMARY OF FINDINGS

Of the 200 Medicaid claims in our statistical sample, 146 did not meet reimbursement requirements. We estimated that local education agencies received at least $2,785,151 (Federal share) in improper payments between July 1, 1999 and June 30, 2000 (State fiscal year 2000).

Federal laws and regulations, State regulations, or the Medicaid State plan requires:

- a prescription from a physician or other practitioner of the healing arts for physical and occupational therapy services and a referral for services to individuals with speech, hearing, and language disorders

- that services be documented and included in a child's individualized education plan or an individualized family service plan (child's plan/family plan)

- provision of speech-language services by or under the direction of a certified speech-language pathologist or an individual with similar qualifications

- maintenance of documentation to support services claimed and payment rates

- provision of public funds as State matching funds under certain conditions

- that payments be necessary, reasonable, and allocable to Federal awards

Of the 146 unallowable claims, 23 had more than 1 deficiency:

- One hundred forty-four claims did not comply with Federal and State regulations requiring a prescription or referral before delivery of services.

- Thirteen claims were not documented or insufficiently documented to support the services rendered.

- Seven claims were not allowable because the services were not rendered or did not qualify under Federal law.

- Three claims lacked a child's plan/family plan.

- Two claims did not comply with Federal requirements that speech services be provided by or under the direction of a certified speech-language pathologist or an individual with similar qualifications.

Furthermore, payment rates for school-based services were not adequately supported.

Additionally, the local education agencies did not always meet the requirements for State matching necessary to claim the Federal share of school-based services costs, primarily because of errors in completing the certifications. There was a shortfall of $138,803 in the designated State matching accounts of two local education agencies. As a result, the State claimed excess Federal funds for the quarters involved. However, these two local education agencies had additional expenditures that would have been eligible for use as the State's match had the certifications been completed accurately and timely.

Finally, the local education agencies were overpaid $281,655 for school-based services. The initial fee-for-service payment tape the State provided to us contained improper payments such as duplicate payments and payments for services that exceeded the State's established service limitations. The State recouped the overpayment and subsequently provided us a new sampling universe.

In our opinion, these deficiencies occurred because the State did not:

- provide the local education agencies with sufficient guidance and oversight to bill Medicaid appropriately

- have adequate policies and procedures to support the Medicaid billing rates for school-based services

- monitor local education agencies to ensure that the State share was met and required certifications were submitted accurately and timely

- have adequate controls to prevent improper payments such as duplicate payments and payments for services that exceeded the State's established service limitations

RECOMMENDATIONS

We recommend that the State:

- refund $2,785,151 to the Federal Government

- provide guidance and oversight to local education agencies so that they meet Federal and State reimbursement requirements

- consult with the North Carolina Medical Board to determine whether physicians should examine the students, review their medical records, or coordinate their medical services with their primary care physicians

- review paid claims for periods after our review to determine whether claims were unallowable and, if so, refund the Federal share

- implement policies and procedures for maintaining documentation to support the Medicaid billing rates for school-based services

- monitor local education agencies to ensure that they timely and accurately report their share of State matching funds

- implement procedures to prevent improper payments and take more timely action on the exception reports that identify duplicate payments and payments for services that exceeded the State's established service limitations.

STATE COMMENTS

State officials generally disagreed with our findings and recommendations. The State's written comments and the Office of Inspector General's (OIG) response are summarized after the "Recommendations" section. The complete text of the State's comments, except for the enclosures that accompanied the response, is included in Appendix C. We excluded the enclosures because of their length, but have forwarded a complete copy to the responsible action official.

OIG RESPONSE

After considering the State's comments, we continue to recommend that the State make a financial adjustment and implement our other recommendations. Where appropriate, we changed the report to reflect documentation the State provided.

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INTRODUCTION

BACKGROUND

Nationwide School-Based Services

Title XIX of the Social Security Act established the Medicaid program in 1965 to provide medical care to pregnant women, children, and needy individuals who are aged, blind, or disabled. Medicaid is a jointly funded Federal and State entitlement program administered by the States. Section 1903(c) of the Social Security Act was amended in 1988 to allow Medicaid coverage of health-related services for children under the Individuals with Disabilities Education Act. The latter Act requires States to provide appropriate special education and related services (school-based health services) to children with disabilities or special needs.

Each State outlines its Medicaid program in a State plan subject to review by the Centers for Medicare & Medicaid Services (CMS) for compliance with Federal requirements. States generally claim Federal funding for school-based services under the categories of administration or medical assistance payments. The North Carolina Department of Health and Human Services, Division of Medical Assistance administers the State's Medicaid program.

North Carolina School-Based Services

Article 9, section 115C-106 to 115C-150 of the North Carolina General Statutes requires that all disabled children between the ages of 3 and 20 receive a free appropriate education. Local education agencies are responsible for furnishing special education and related services as defined in a child's plan/family plan.

In 1991, North Carolina requested CMS approval to add school-based health services to its State Medicaid plan and to receive Federal funding. On September 13, 2001, CMS granted the request with an effective date of September 25, 1995. Allowable school-based health-related services are based on reasonable cost. During State fiscal year 2000, Medicaid costs for school-based health-related services totaled $4,221,981 (Federal share).

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

Our objectives were to determine whether (1) claims for school-based services were allowable under Federal and State requirements, (2) payment rates were supported and reasonable, and (3) the State share for claiming Federal funding was met.

Scope

Our audit covered North Carolina Medicaid school-based services provided during State fiscal year 2000. We limited our review of internal controls to those controls considered necessary to achieve our objectives. Specifically, we obtained an overall understanding of State policies and procedures through discussions with the State and local education agencies. We also obtained an understanding of the State's internal controls relating to the rate development process and claims processing.

Methodology

We reviewed Federal and State laws, regulations, and guidelines pertaining to the Medicaid program and the provision of school-based health services. We held discussions with officials from the State, CMS, local education agencies and their consultants, and other health officials.

We requested that the State provide us a computer file containing paid fee-for-service claims. Our analysis of this file disclosed potential anomalies such as duplicate payments and payments that exceeded State-established parameters. These anomalies included payments for the same services rendered to the same recipient by more than one provider on the same date, payments for the same services rendered to the same recipient on the same date and billed under more than one program, payments for services beyond State-established limitations, and provider billing errors where the same service details were billed on more than one original claim.

After we brought these potential overpayments to their attention, State officials identified and recouped $281,655. State officials also provided us with a revised paid claims universe covering State fiscal year 2000 for 51 local education agencies. We used this paid claims universe to randomly select a statistical sample of 200 beneficiary/months from a population of 108,805 beneficiary months. Appendix A contains our sampling methodology.

We judgmentally selected 8 of the 51 local education agencies for a documentation review to determine if the State-share certifications for State fiscal year 2000 were correct. We verified the local education agencies' Medicaid receipts and the State's matching requirement. We selected expenditures for a detailed review to determine whether local education agencies used allowable expenditures for the State's match.

We performed fieldwork at the Division of Medical Assistance offices in Raleigh, NC; the 34 local education agency sites; physician offices in Mamers and Wilmington, North Carolina; and the CMS regional office in Atlanta, Georgia. We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We found significant noncompliance with Federal and State requirements. Of the 200 sampled claims, 146 did not meet reimbursement requirements. We estimated that local education

agencies received at least $2,785,151 (Federal share) in improper payments between July 1, 1999 and June 30, 2000.

Of the 146 unallowable claims, 23 had more than 1 deficiency. The table below summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix B shows our determination on the allowability of each sampled claim.

Type of Deficiency	Number of Unallowable Claims[1]
Prescription or referral requirements not met	144
Services undocumented or insufficiently documented	13
Services not provided or did not qualify	7
Services not included in child's plan/family plan	3
Provider qualifications not met	2

We also found the following conditions:

- Payment rates for school-based services were not adequately supported.

- The local education agencies did not always meet the requirements for State matching necessary to claim the Federal share of school-based services costs, primarily because of errors in completing the certifications. There was a shortfall of $138,803 in the designated State matching accounts of two local education agencies. As a result, the State claimed excess Federal funds for the quarters involved. However, these two local education agencies had additional expenditures that would have been eligible for use as the State's match had the certifications been completed accurately and timely.

- The local education agencies were overpaid $281,655 for school-based services. The initial fee-for-service payment tape the State provided to us contained improper payments such as duplicate payments and payments for services that exceeded the State's established service limitations. The State recouped the overpayment and subsequently provided us a new sampling universe.

DEFICIENCIES NOTED IN SAMPLED CLAIMS

The sections below discuss the five types of deficiencies noted in the sampled claims and the criteria that we applied in determining the allowability of claims. These conditions occurred because the State did not provide the local education agencies with sufficient guidance and oversight to bill Medicaid appropriately for school-based health services.

[1] Total exceeds 146 because 23 claims contained more than 1 error.

Prescription or Referral Requirements Not Met

Federal regulations (42 CFR § 440.110) require a prescription from a physician or other practitioner of the healing arts for physical and occupational therapy services or a physician's referral for services provided to individuals with speech, hearing, and language disorders.

For 144 sampled claims, the physician prescription or referral did not comply with Federal requirements. These included 135 instances where services were rendered before the date of the physician prescription or referral, 3 instances where no physician prescription or referral was obtained, 3 instances where the service date(s) on the physician prescription or referral did not correspond to those in our sample, and 3 instances where the prescription or referral was not dated.

In some cases, services were provided a year or more before the date of the physician prescription or referral, even though the State requires physician authorization before delivery of services.

We also observed that physicians were authorizing school-based health services without examining the students, reviewing their records, or coordinating services with the students' primary care physicians. Local education agencies generally interpreted the physician prescription or referral requirements of 42 CFR § 440.110 as mandating a signature only, with no direct physician involvement in the services. Physicians authorized school-based health services by signing prepared lists that included the names and services for hundreds of students.

Services Undocumented or Insufficiently Documented

Federal regulations at 42 CFR §§ 431.17 and 433.32 and an August 1997 CMS guide, "Medicaid and School Health: A Technical Assistance Guide," require that services claimed for Federal Medicaid funding be documented. We identified 13 claims where the required information was either unavailable for review or lacked sufficient documentation. These included five claims where the Medicaid claim was missing, five claims where the provider credentials were missing, and three claims where the assessment results were missing.

Services Not Provided or Did Not Qualify

To be allowable under Federal awards, costs must be allocable in accordance with the relative benefits received (Office of Management and Budget (OMB) Circular A-87, Attachment A, C.3.a). We identified seven claims where the services either were not provided or did not qualify under the Individuals with Disabilities Education Act. Three claims were for services when the student was designated absent from school, and three claims were for services that were not provided. One claim was for services to a student who did not qualify under the Individuals with Disabilities Education Act.

Services Not Included in Child's Plan/Family Plan

Section 1903(c) of the Social Security Act permits Medicaid payment for school health services that are identified in a child's plan/family plan. Under part B of the Individuals with Disabilities Education Act, local education agencies must prepare, for each child, a plan that specifies all needed special education and related services.

In three of the sampled claims, local education agencies did not provide a child's plan/family plan.

Provider Qualifications Not Met

Federal regulations at 42 CFR § 440.110(c)(2) and the Medicaid State plan require that speech-language providers be certified by the American Speech and Hearing Association or hold equivalent qualifications. According to the American Speech and Hearing Association guidelines, an individual must have successfully completed a graduate degree (masters or doctorial) program. For two claims in our sample, the speech-language clinicians did not possess the necessary educational requirements.

Estimation of the Unallowable Claims

On the basis of our sample, we estimate that the Federal share of overpayments for North Carolina Medicaid school-based services was $2,785,151. This amount is the lower limit of the 90-percent confidence interval (see Appendix A).

PAYMENT RATES

Requirements relating to payment rates can be found in the Medicaid State plan at section 4.19(h) and in 42 CFR §§ 447.201 and 447.203. Under 42 CFR § 447.201, a State plan must describe the policy and methods to be used in setting payment rates for each type of service included in the State's Medicaid program. Additionally, under 42 CFR § 447.203, a Medicaid agency must maintain documentation on payment rates and make it available to the Department of Health and Human Services upon request.

The payment rates for school-based health services were not adequately supported. The rates were based on a State analysis. Documentation to support the assumptions used and amounts computed was not available. The State should maintain adequate documentation to support the development of the rates, including all factors and assumptions used in the computations.

STATE-SHARE CERTIFICATIONS

Federal regulations at 42 CFR § 433.51 and State policy describe the requirements for State matching necessary to claim the Federal share of school-based health service costs. Under certain conditions, public funds, such as the non-Federal expenditures that local education

agencies incur, may be considered as the State's share. Local education agencies must certify each quarter that they have expended the required non-Federal match for Medicaid-reimbursed services.

The local education agencies did not always meet the requirements for State matching necessary to claim the Federal share of school-based costs, primarily because of errors in completing the certifications. There was a shortfall of $138,803 in the designated State matching accounts of two local education agencies. As a result, the State claimed excess Federal funds for the quarters involved. However, these two local education agencies had additional expenditures that would have been eligible for use as the State's match had the certifications been completed accurately and timely.

In addition, the eight local education agencies selected for this audit did not submit the State-share certifications quarterly. Officials told us that certifications had not been prepared in years and were only being prepared in response to our audit. We found that the certifications were prepared retroactively to 1996.

We noted the following deficiencies in the certifications:

- One local education agency had not completed the required quarterly certifications.

- One local education agency prepared an annual certification instead of the required quarterly certifications.

- Four local education agencies were unable to reconcile the certified Medicaid receipts and their accounting records.

- One local education agency used the wrong fiscal year data when preparing the certifications.

- Five local education agencies used the wrong matching rate for at least 1 quarter in State fiscal year 2000.

- Two local education agencies did not meet the State-share matching requirements because of errors in completing the certifications.

We believe these conditions occurred because the State did not provide adequate guidance to the local education agencies or exercise sufficient oversight of their activities.

OVERPAYMENTS TO LOCAL EDUCATION AGENCIES

Federal regulations require that payments be necessary, reasonable, allocable to Federal awards, and not prohibited under State laws or regulations (OMB Circular A-87, Attachment A).

The local education agencies were overpaid $281,655 because the State did not have adequate controls to detect duplicate payments or prevent payments for school-based services that exceeded State service parameters. Our analysis of the initial fee-for-service payment tape that the State provided to us contained the following improper payments to local education agencies:

- true duplicates – payments for the same services rendered to the same beneficiary by the same local education agency on the same date

- different providers – payments for the same services rendered to the same beneficiary by different providers on the same date

- different programs – payments for the same services rendered to the same beneficiary on the same date and paid under more than one Medicaid program (i.e., the local education agency program and the Individual Practitioner Program)

- service parameters exceeded – payments for services beyond the State's established service limitations

- system errors – payments for provider billing errors

The State did not establish processing criteria that would automatically deny duplicate claims or take action to prevent payments for services that exceeded the service parameters. The State established "report audits" to reflect the service parameters for school-based health services, but these audits did not affect the processing of local education agency claims. Instead, the audits generated an exception report that the fiscal agent sent to the State for corrective action, which the State did not take. The State identified and recouped $281,655 in improper payments after we brought these errors to its attention.

RECOMMENDATIONS

We recommend that the State:

- refund $2,785,151 to the Federal Government

- provide guidance and oversight to local education agencies so that they meet Federal and State reimbursement requirements

- consult with the North Carolina Medical Board to determine whether physicians should examine the students, review their medical records, or coordinate their medical services with their primary care physicians

- review paid claims for periods after our review to determine whether claims were unallowable and, if so, refund the Federal share

- implement policies and procedures for maintaining documentation to support the Medicaid billing rates for school-based services

- monitor local education agencies to ensure that they timely and accurately report their share of State matching funds

- implement procedures to prevent improper payments and take more timely action on the exception reports that identify duplicate payments and payments for services that exceeded the State's established service limitations

STATE COMMENTS AND OIG RESPONSE

State officials generally disagreed with our findings and recommendations. The State's comments and OIG's response are summarized below. The State also provided specific comments on selected claims. We have considered those comments and have revised our report where appropriate.

State Comments on Sample Selection and Extrapolation

The State disagreed with our sampling methodology, saying that an unrestricted random sample was inefficient and that the 34 local education agency sites we visited were not homogeneous. They also stated that although inferences can be extrapolated to the entire State, ". . . the results are unreasonable in that there is no way to assign dollar disallowances to the specific entities across the state . . . ." The State suggested that the OIG's sample should have been stratified by local education agency so that extrapolations (disallowances) could have been made for each agency.

OIG Response

The State's response is without merit. Our sampling methodology was in accordance with OIG policy, and the sample represented a valid random sample of statewide expenditures for school-based health services.

The fact that we did not project an error for each local education agency does not invalidate our sample. Our objective was to determine whether claims for school-based services were allowable under Federal and State requirements. We did not sample local education agencies; we sampled beneficiary months. During State fiscal year 2000, 51 local education agencies

throughout the State received Medicaid payments for school-based health services. A sample stratified by local education agency was not realistic. Moreover, OIG was conservative by only seeking recovery of the lower limit.

State Comments on Physician Prescriptions or Referrals

Officials said the State requires physician orders for Medicaid billing purposes only. Further, North Carolina's professional practice laws allow licensed practitioners of the healing arts to self-refer, and therefore physician orders are not required for school-based physical therapy, occupational therapy, speech pathology, or audiology services. In addition, the nature of school-based services and State licensure requirements for professionals in allied medical disciplines, such as speech therapy, made referrals unnecessary.

OIG Response

We agree that the State requires physician orders for Medicaid billing because physicians authorize the delivery of Medicaid services as medically appropriate.

However, contrary to the State's assertion, State laws for physical therapy, occupational therapy, and speech pathology and audiology (North Carolina General Statutes, Articles 18B, 18D, and 22, respectively) do not explicitly allow these practitioners to practice without physician prescriptions, referrals, or orders and without physician direction. In any case, 42 CFR § 440.110 requires a prescription for physical and occupational therapy services and a referral for services to individuals with speech, hearing, or language disorders. To comply with these regulations, the State required that a physician authorize the services.

We disagree with the State's contention that the nature of school-based health services and the requirements for the professionals in allied medical disciplines do not make it critical to have physician approval. The place of service does not change the nature of the service being provided. As such, they do not differ from the medical services provided in any other health care setting.

State Comments on Physician Prior Authorization

The State said that it could find no authority for the use of the term "prior" in any authoritative source and that, as a result, it was improper to retroactively require prior approvals. The State also said that during the audit period, its rules regarding physician orders and prior authorization for school-based services were in a state of flux. In its written comments, the State cited two pieces of 1999 correspondence as evidence that prior authorizations were no longer required.

OIG Response

States frequently adopt prior approval requirements to serve as a control for the overutilization of Medicaid services and to satisfy the Medicaid requirement that services be medically necessary.

According to information contained in a letter from the North Carolina Attorney General's office in response to a question concerning physician services, "Only physicians can determine medical necessity . . . the process of obtaining a physician's determination of medical necessity is well within usual and customary medical practices in North Carolina . . . ."

Contrary to North Carolina's assertion, the 1999 correspondence did not provide evidence that prior authorizations were no longer required for school-based services. The correspondence referred to the elimination of the requirement for the Purchase of Medical Care Services' approval of the treatment authorization form. In a letter dated February 6, 2001, the Division of Medical Assistance Director stated that local education agencies ". . . have always and continue to be required to have physician orders before delivering any treatment services to Medicaid recipients."

State Comments on Physician Services

The State said that OIG was inserting physician referral requirements into a health care delivery model where such requirements did not fit. According to the State, local education agencies provide physicians with lists of students and request the physicians to approve the services in the students' individualized education plans. The local education agencies select physicians who have knowledge of and/or experience with school-based health services. The State also said that some of the physicians have worked under contract with local education agencies or with county programs treating children with special needs.

OIG Response

Local education agencies chose some physicians who had no knowledge of either the students or the clinicians providing school-based health services. For example, one emergency room physician who authorized school-based health services stated that he (1) considered the services as medical services, (2) had no knowledge of or experience with school-based health services or the children receiving the services, and (3) never met the clinicians providing the services. The physician neither examined the children nor reviewed the student records. While not provided for in Federal or State regulations, we believe that at a minimum, a child's primary care provider should approve all school-based services for that child or should be notified to ensure that the child's overall health care is well coordinated.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE

To determine the amount of Medicaid fee-for-service payments for school-based services in North Carolina that did not meet the requirements of the Medicaid State plan and applicable Federal and State regulations.

POPULATION

Our universe consisted of 108,805 beneficiary/months totaling $4,221,981 for school-based services where the date paid was between July 1, 1999 and June 30, 2000 (State fiscal year 2000).

SAMPLE UNIT

The sample unit was a beneficiary/month: all the services for a beneficiary for a month.

SAMPLE DESIGN

We used an unrestricted random sample.

SAMPLE SIZE

We reviewed a sample of 200 randomly selected beneficiary/months.

ESTIMATION METHODOLOGY

We used the Office of Audit Services RAT-STATS Variable Appraisal program to project the costs of the unallowable services.

RESULTS OF STATISTICAL SAMPLE

We identified overpayments in 146 of the 200 sample units. The total value of the overpayments in the sample was $6,056 (Federal share).

We used the results of the 200 sample items to project the value of the overpayments for the population of 108,805 beneficiary/months. The results of the projection are:

Point Estimate of Differences:	$3,294,828
90% Confidence Interval	
Lower Limit:	$2,785,151
Upper Limit:	$3,804,505
Precision Amount:	$ 509,677
Precision Percent:	15.47%

ALLOWABILITY OF EACH SAMPLED CLAIM

Legend

A	Claim Missing
B	Child's Plan/Family Plan Missing
C	Assessment Results Missing
D	Services Rendered Before Date of Authorization
E	Physician Authorization Missing
F	Physician Authorization Did Not Match Service Dates
G	Authorization Not Dated
H	Provider Qualifications Not Met
I	Provider Credentials Missing
J	Student Absent on Date of Services
K	Services Not Provided on Date of Claim
L	Student Not Eligible

OIG Review Determinations on the 200 Sampled Claims

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
1													0
2				X									1
3				X									1
4													0
5				X									1
6													0
7													0
8				X									1
9				X									1
10				X									1
11				X									1
12				X									1
13													0
14							X						1
15							X				X		2
16							X						1
17													0
18											X		1
19				X									1
20													0
21													0
22				X									1
23													0
24				X									1

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
25				X									1
26				X									1
27													0
28	X			X									2
29	X			X									2
30	X			X									2
31	X			X									2
32	X			X									2
33				X									1
34				X									1
35						X		X					2
36				X									1
37		X											1
38													0
39													0
40													0
41													0
42				X									1
43				X						X			2
44				X									1
45				X									1
46				X					X				2
47				X									1
48				X									1
49				X									1
50				X									1
51				X									1
52				X									1
53				X									1
54				X									1
55				X									1
56				X						X			2
57				X									1
58				X									1
59													0
60				X									1
61													0
62				X									1
63				X									1
64													0
65				X									1
66				X						X			2

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
67				X									1
68				X									1
69				X									1
70				X									1
71				X									1
72													0
73													0
74													0
75													0
76				X									1
77				X									1
78				X									1
79				X									1
80				X									1
81				X									1
82													0
83													0
84													0
85				X									1
86				X									1
87				X									1
88				X									1
89				X									1
90				X					X				2
91				X									1
92				X									1
93				X									1
94					X								1
95													0
96									X				1
97				X									1
98				X									1
99				X									1
100				X									1
101				X									1
102													0
103				X									1
104			X	X									2
105				X									1
106				X									1
107				X									1
108				X									1

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
109				X									1
110				X									1
111				X									1
112		X		X									2
113				X									1
114													0
115				X									1
116				X									1
117				X					X				2
118													0
119					X							X	2
120													0
121				X									1
122									X				1
123				X									1
124				X									1
125			X	X									2
126				X									1
127													0
128				X									1
129				X	X								2
130													0
131				X									1
132				X									1
133													0
134													0
135													0
136				X									1
137				X									1
138				X				X					2
139													0
140													0
141				X									1
142				X									1
143													0
144				X							X		2
145													0
146				X									1
147			X	X									2
148				X									1
149				X									1
150													0

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
151													0
152				X									1
153				X									1
154				X									1
155				X									1
156				X									1
157				X									1
158				X									1
159				X									1
160				X									1
161													0
162													0
163													0
164													0
165				X									1
166		X		X									2
167													0
168													0
169				X		X							2
170				X									1
171													0
172													0
173						X							1
174													0
175				X									1
176				X									1
177				X									1
178													0
179													0
180													0
181				X									1
182				X									1
183				X									1
184				X									1
185				X									1
186													0
187				X									1
188				X									1
189				X									1
190				X									1
191				X									1
192				X									1

Claim No.	A	B	C	D	E	F	G	H	I	J	K	L	No. of Errors
193													0
194				X									1
195				X									1
196				X									1
197				X									1
198				X									1
199				X									1
200				X									1
Total	5	3	3	135	3	3	3	2	5	3	3	1	

North Carolina Department of Health and Human Services
2001 Mail Service Center • Raleigh, North Carolina 27699-2001
Tel 919-733-4534 • Fax 919-715-4645

Michael F. Easley, Governor

Carmen Hooker Odom, Secretary

May 19, 2003

Transmitted by fax:
404-562-7795

Reference: CIN: A-04-01-00005

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Office of Inspector General - Office of Audit Services
Room 3T41, Atlanta Federal Center
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

Dear Mr. Curtis:

We have received your March 17, 2003 letter and draft report entitled, *Audit of Medicaid Fee-for-Service Payments to Local Education Agencies in North Carolina for the period July 1, 1999 through June 30, 2000.* We appreciate the time extension granted the Department to provide the following response.

General Comments

- **Original Documentation.** We contacted the counties from which the audit samples were drawn and requested copies of documents that were cited in the draft report as "missing." In many instances, "missing documentation" was located and is attached to this response. (See attached **Schedule 1.**) Additional documentation is still being received as of the date of this response.

- **Sample Selection and Extrapolation.** The auditors state that an unrestricted random sample of 200 beneficiary months was used which resulted in the selection of 34 Local Education Agency (LEA) sites. While we have no problem with the use of statistical sampling, the use of an unrestricted random sample was not the most

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efficient means of sampling. The 34 sites visited are not homogeneous nor do they constitute a single entity but are 34 independent and distinct provider/entities that provide services, each under the control of a different government agency. And while inferences and conclusions can be drawn (extrapolated) to the total universe, the results are unreasonable in that there is no way to assign dollar disallowances to the specific entities across the State, some of whom did not have a single case pulled in the sample.

An analogy would be for the Internal Revenue Service to:

- select an unrestricted random sample of tax returns of auditors nationwide,
- audit the sample which results in an average $1,000 payback,
- then to require all auditors in the nation to pay back funds based on the sample extrapolation.

To make another analogy, the OIG could likewise decide to:

- isolate on a particular Medicare service,
- select an unrestricted random sample of cases state-wide or nation-wide and based on that sample,
- make inferences/disallowances relating to Federal funding for all medical providers in the State or Nation that provided that type of Medicare service.

However, medical providers are different entities having different management structures, internal processes, ownership, etc. and do not represent homogeneous populations. And while conclusions may be reached as to estimated errors in the total population, there is no reasonable way of assigning these errors/paybacks to specific entities.

> Therefore, it would be inappropriate to assess a payback to each medical provider unless the sample was stratified for each medical provider.

Disallowances in this audit should be limited to specific cases found to be deficient in critical Federal requirements since the sample was not stratified by service provider. If the sample had been stratified by LEA units, then extrapolations (disallowances) could have been made for each entity based on the sample results for that particular entity.

OIG Note: The State's comments have been deleted because the comments pertain to material that is no longer in this report.

OIG Note: The State's comments have been deleted because the comments pertain to material that is no longer in this report.

OIG Note: The State's comments have been deleted because the comments pertain to material that is no longer in this report.

OIG Note: The State's comments have been deleted because the comments pertain to material that is no longer in this report.

B. Physician Prescriptions/Referrals

Another draft finding stated that physician prescriptions/referrals did not comply with federal and State requirements. We disagree with this position for the following reasons.

> Note: The terms physician "prescriptions", "referrals", "authorization", are used intermittently in the OIG and DMA documents. In this response to the OIG draft report, these terms will be considered interchangeable.

Although required by the State for Medicaid billing purposes only, neither Federal Medicaid rules nor the State's professional practice laws require physician orders for school-based physical therapy, occupational therapy, speech pathology and audiology services.

The draft report referenced the requirements in the Code of Federal Regulations (CFR) regarding physician prescriptions and referrals for school-based services, but failed to fully state the rule. Title 42 of the CFR, section 440.110, is more fully stated as follows:

> *"Physical and occupational therapy services must be prescribed by a physician **or other licensed practitioner of the healing arts within the scope of practice under the state's law** and be provided by or under the direction of a qualified licensed physical therapist or occupational therapist. Services for individuals with speech, hearing or language disorders means diagnostic, screening, preventive or corrective services provided by or under the direction of a speech pathologist or audiologist, for which the patient is referred by a physician **or other licensed practitioner of the healing arts.**"* (Emphasis added)

"Licensed practitioners of the healing arts" are determined by the professional practice standards established by each State. These standards dictate the scope of clinical practice for the various health care practitioners within the State. Chapter 90 of the NC General Statutes contains the State's practice standards for medicine and allied occupations. The Articles addressing:

- physical therapy (Article 18B),
- occupational therapy (Article 18D), and
- speech pathology and audiology (Article 22)

allow these practitioners to practice *without* physician prescriptions, referrals, or orders and *without* any physician direction. The ability to evaluate health care needs and to determine and implement a plan of treatment without physician involvement inherently includes the ability of these practitioners to self-refer. This outcome is supported by national professional practice organizations, including the American Speech-Language-Hearing Association, and the American Physical Therapy Association. (Please see the quote in Section 4 of this Response to the Draft Report.)

Further, North Carolina has had **"direct access"** since the 1985 authorization by the General Assembly (Example physical therapy: G.S. 90-270.24 to 90-270.39). Direct access allows for the practice without the legal requirement of a physician's referral. (http://www.ncptboard.org/Documents.asp?Type=P)

Question: Does North Carolina allow direct access (practice without the legal requirement of a physician's referral) and where can I find it in the NC PT Practice Act?

Answer: North Carolina has had direct access since 1985 when the Practice Act was revised in 1985 by the NC General Assembly.

Similarly, Legal Counsel for the North Carolina Board of Occupational Therapy likewise states that *"North Carolina does not require physician referral for providing occupational services."*

While we agree that physician referrals are important in the vast majority of health care cases, the nature of school-based health services and the State licensure requirements for the professionals in these allied medical disciplines such as speech therapy do not make it critical to have physician approval. In fact, in many instances, the evaluation of a child by one of the school health professionals and the transfer of this information to the physician after the evaluation and/or treatment makes the most practical sense and is the most cost-effective approach for Medicaid funds.

Therefore, school-based health services provided by properly licensed health care practitioners, even without prior physician's orders, were within scopes of their respective practices under State law. Accordingly, Medicaid reimbursement for these services was consistent with federal Medicaid rules for school-based services.

C. Physician Prior Authorization

A third draft finding questioned the validity of reimbursement for services provided prior to the date of the physicians' orders. We could find no authority for the use of the term "prior" in any authoritative source. Therefore, it is improper for the auditors or DMA to retroactively require "prior" approvals. We did find terminology such as "confirm" which actually implies an after-the-fact approval as opposed to a "prior" approval. As such, LEAs should not be penalized where there is reliance on reasonable interpretations of the law.

During the OIG audit period, the NC rules regarding physician orders and prior authorization for school-based services were in a state of flux. For instance, the State's billing manual for LEAs that was in effect in 1999 required treatment to be prior authorized by the Division of Maternal and Child Health. However, DMA issued at least two correspondences, one dated May 27, 1999 and another dated November 16, 1999 stating that prior authorizations were no longer required for IEP/IFSP treatment services provided by LEAs.

DMA issued correspondences to LEAs stating that physicians' orders must be obtained "**prior to submitting a claim**" or "**before a claim can be processed**". However, we find no authoritative source from DMA that requires physician orders to be obtained ***prior to service delivery.*** To impose a "prior to service delivery" would often result in delays in the delivery of services to children with special health care needs as prescribed in their respective IEP/IFSPs. Such delays would also cause LEAs to be in violation of the Individuals with Disabilities Education Act (IDEA)[U.S.C. § 1400, et seq.], which requires that LEAs provide services to students as prescribed in their IEP/IFSPs and supports the new federal No Child Left Behind requirements. It should also be noted that, in its managed care program, DMA allows retroactive physician authorization of services at the discretion of the primary care provider. (See "Carolina Access Overview".)

Based on the foregoing, reimbursement was permissible for services provided prior to obtaining physician orders for the services. LEAs complied with DMA rules in that services were not billed until the physician orders for such services were obtained.

D. Physician Services

This finding dealt with the OIG perception that "physicians were authorizing school-based health services without examining the students, or at a minimum, reviewing the student records." This is the result of inserting physician referral requirements into a health care delivery model where such requirements simply do not fit. The State's requirements for physicians' orders for IEP/IFSP services provide little or no demonstrated benefit to the patient nor to the State for school-based health services. In fact, a physician referral would be both costly and time-consuming since it would result in delays in providing clinician services. A strict requirement for physician referral would divert scarce fiscal resources with little or no cost- benefit. On the other hand, licensed school health providers are required by law to notify primary physicians at the time of evaluation or treatment if it is determined that the patient's condition is beyond the scope of practice of the clinician, i.e. physical therapist.

School-based Medicaid services should be responsibly designed and effective without being cumbersome, inappropriate or unnecessary. Certain issues suggested in the audit would be ineffective, costly and delay provision of services to students. For example, the audit's interpretation of NC School-based Medicaid services would require the parents/guardians of Medicaid-eligible students to take the time and incur the expense of removing their children from school for a physician office visit to obtain orders for school-based health services that are already prescribed by the student's IEP/IFSP based on a variety of clinical screenings, assessments, and evaluations to determine health care needs. Parents/guardians have little incentive to do this, which means that the child would never qualify for or receive Medicaid school health services. Additionally, many

of the counties/LEAs lack sufficient funds to pay the total cost of services with local dollars. Rather than improving the general health of school children, we would likely see a decline.

LEAs have made reasonable efforts to comply with the rules by implementing a process to obtain the required physician-signed orders. The LEAs provide physicians with lists of students with IEP/IFSP service requirements requesting the physicians' signed approvals of treatment. The LEAs select physicians for this role who have knowledge of and/or experience with school-based health services. Some of the physicians selected have worked under contract with LEAs or with county programs treating children with special needs. These physicians understand the nature of the services they are approving.

The draft report expresses the belief that:

> *"inherent to a physician's signature, or authorization for services, is the expectation of the delivery of patient care in accordance with the standards of acceptable medical practice. We believe these standards require direct physician involvement when prescribing/referring patient services."*

Although these statements are basically true, they do not represent dogma and reflect a lack of understanding of the nature of the rehabilitative services provided in the school setting to children with disabilities. These children often need the ***specialized*** services of a physical therapist, occupational therapist, speech pathologist, and/or audiologist. The fact that an individual may be an extremely qualified physician in a certain field does not necessarily mean that he/she also has extensive expertise in any of these school health care fields. As such, physicians should not automatically be deemed to possess better expertise in order to diagnose, prescribe and/or verify the appropriateness of IEP/IFSP treatment plans than the allied licensed medical professionals specifically educated and trained to perform such school health services.

Federal Medicaid rules at 42 CFR 440.110, set forth above, do not require any physician involvement or oversight in the delivery of the subject therapy services, nor do NC professional practice statutes impose such requirements. Therapists should be allowed to use their own professional and clinical judgment to determine when physician involvement in treatment would be in the best interest of the child. This approach will avoid unnecessary and duplicative services and expense.

The position that school-based providers are capable of determining the service requirements in their specific field for students, without physician involvement, is consistent with the determinations made by national professional organizations that set the educational, certification, ethical, and practice standards for these providers. For instance, the American Speech-Language-Hearing Association, a national organization that accredits education programs and sets national certification standards for speech pathologists and audiologists states:

> *"As primary care providers for communication, swallowing, or other upper aerodigestive disorders, speech-language pathologists are autonomous professionals; that is, their services need not be prescribed or supervised by individuals in other professions. However, in many cases individuals are best served when speech-language pathologists work collaboratively with other professionals."*

Although physician involvement is seldom necessary in the delivery of speech therapy services, speech pathologists collaborate frequently with other school-based practitioners and teachers to coordinate services provided to students and to monitor each student's progress. Collaboration is also made with physicians when appropriate. This is also true of the other clinical disciplines.

We agree with the draft report which states that "*it is good medical practice for physicians and other medical providers to communicate with each other when multiple providers provide services to the same patient.*" However, we do not take this to the

extreme conclusion that, in all cases, the term "other medical providers" must include a physician.

E. Unallowable Services

Three attributes were covered in this finding which are elaborated on below.

- **Student Absent – Attribute 11**

  Appendix B (No. 43 - Iredell). The child in question has a history of very sporadic attendance both in terms of absences and tardies. For example, in 2001-2002 the child had 106 days absent and 17 days tardy. The 106 days absent is somewhat misleading in that children are considered absent if they are in attendance for less than half a day. It would be very easy for the record to show the student as absent when in reality the child was present for a portion of the day. Thus, the attendance sheet and the service sheet could superficially appear contradictory, yet in reality, both could be correct—that is, the child could be counted absent yet have attended for a portion of the day.

  In this case, we have to look at other documentation. The licensed clinician signed that the services were provided on the billing form that reflects the services. This should carry significant weight since the school system receives the funds and there is no personal gain for the clinician to falsely certify that services were provided. The clinician is unlikely to put their professional license on the line when the LEA is the beneficiary of the Medicaid billing. Government Auditing Standards (GAS) stipulate the types of documentation that can be considered as evidentiary documentation. GAS even allow testamentary or verbal documentation. GAS *Chapter 6: Field Work Standards for Performance Audits* is much broader than the approach taken in the audit report.

> *6.47 Evidence may be categorized as physical, documentary, testimonial, and analytical. Physical evidence is obtained by auditors' direct inspection or observation of people, property, or events. Such evidence may be documented in memoranda, photographs, drawings, charts, maps, or physical samples. Documentary evidence consists of created information such as letters, contracts, accounting records, invoices, and management information on performance. Testimonial evidence is obtained through inquiries, interviews, or questionnaires.*

Thus, we feel that this should not be considered an error despite the ostensible contradiction.

Appendix B (No. 56) See general comments on No. 43.

Appendix B (No. 66) See general comments on No. 43.

- **Services not provided on claim date --Attribute 12**

Appendix B #15 (Halifax) The child in question was seen on two consecutive days, Oct 21 and 22. The therapist had handwritten notes for Oct 22 which was provided during the audit. This child had severe problems with *"feeding and swallowing skills...difficulty with lip closure on bottle...increased spitting up and decreased oral-motor flexibility."* It is obvious that there was no measurable change in 24 hours between the therapy without handwritten notes and the therapy with handwritten notes. The therapist has provided typed notes for the day of services. Documentation is attached.

Appendix B. #18 (New Hanover) We agree that the child's Speech Therapy Record did not have a notation on the date of service. Typically, the missing entry would be a cryptic notation on that calendar day such as "T3". However, the scanning sheet does have the information and is signed by the clinician. Governmental Auditing Standards, which govern this report, do allow for such documentation.

Appendix No. 144 (Lincoln). The scanned data sheet had six service dates during the month of January 1997 and the billing to Medicaid reflected seven dates. Six of the seven services should be allowable for the month. The county LEA has not

been able to determine the reason for the seventh billing.

- **Student not eligible – Attribute 13**

Appendix B # 119. We agree that the student should have been billed for assessment services and not for treatment services on 3/12. However, the rate is the same for both services. The 3/19 service was properly billed.

F. Provider Qualifications

Appendix B #46. The North Carolina Board of Physical Therapy Examiners web-site documents that the therapist held a valid license during the time of audit. Documentation is attached.

Appendix B #47. The North Carolina Board of Physical Therapy Examiners web-site documents that the therapist held a valid license during the time of audit. Documentation is attached.

Appendix B #66. The North Carolina Board of Physical Therapy Examiners web-site documents that the therapist and assistant held a valid license during the time of audit. Therapist supervised the assistant. Documentation is attached.

Appendix B #76. The North Carolina Board of Examiners for Speech & Language Pathologists and Audiologists web-site documents that the health provider was a licensed speech and language pathologist during the time of the audit. Documentation is attached.

Appendix B #87. The North Carolina Board of Examiners for Speech & Language Pathologists and Audiologists web-site documents that the health provider was a licensed speech and language pathologist during the time of the audit. Documentation is attached.

Appendix B #90. The North Carolina Board of Examiners for Speech & Language Pathologists and Audiologists web-site documents that the health provider was a

licensed speech and language pathologist during the time of the audit. Documentation is attached.

Appendix B #96. The therapist had a master's degree which is considered as an equivalent certification.

Appendix B #100. The North Carolina Board of Physical Therapy Examiners web-site documents that the therapist held a valid license during the time of audit. Documentation is attached.

Appendix B #117 and #122. The therapist had a master's degree which is considered as an equivalent certification. (Same therapist for both cases.)

Appendix B #154. The North Carolina Board of Examiners for Speech & Language Pathologists and Audiologists web-site documents that the health provider was a licensed speech and language pathologist during the time of the audit. Documentation is attached.

Conclusion

Janet Rehnquist's position that *"As a standard practice, the audit staff routinely favors the State whenever there is reasonable doubt or uncertainty on the allowability of a particular case"* is an appropriate stance for both the OIG and for the Division of Medical Assistance. There is certainly latitude for differences in interpretation. We must always keep in mind the substantive aspects of these services more so than the form of documentation which can vary from provider to provider. This statement is not intended to minimize the importance of documentation, but to put it in perspective. The school health program is an outstanding program that provides allied medical services to some of our most vulnerable children—many of whom would not receive care outside of the school-based health system. Therefore, we have an extremely strong commitment to this area of child health.

We also agree that providers can always strengthen their documentation. However, we must not make the system such a bureaucratic nightmare that providers shun the system.

We already have providers who feel that Medicaid receipts are not worth the hassle. While we might shrug off this provider response, the bottom line is that some of the State's most vulnerable children will suffer. Counties and the State have had to cut services due to the downturn in the economy. There are no additional resources to supplant any lost Medicaid dollars. And millions of dollars in suggested paybacks will further exacerbate the situation.

NC DHHS is in the initial stages of re-examining our entire Medicaid program including school health. We want our system to exemplify the best in the entire country. We also recognize that this will not be a quick fix nor represent a band-aid approach. However, we are reviewing our entire business structure ranging from our organizational structure to our policies and procedures to our contract agent. We are hopeful, indeed optimistic, that this re-engineering process will result in great benefits to the local, State and Federal governments. And last, but not least, we want to improve the health and welfare of our citizens.

Thank you for the opportunity to respond to the draft audit. We trust that our comments and the additional information provided will be helpful in formulating the final report. We also appreciate the courtesies extended by the OIG staff who conducted the audit.

Sincerely yours,

Carmen Hooker Odom

CHO:ds

Enclosure – Confidential Documentation

Cc: Lanier Cansler
Nina Yeager
Dan Stewart
Honorable Ralph Campbell
Satana Deberry
Marc Lodge
Gary Fuquay

Schedule 1

Attribute 1 - Progress/Treatment Notes Missing

See response narrative and the following documents:

Appendix B (No. 15 – Halifax). Physical Therapy Visit Reports have been provided for the following dates of service: 10/4/99, 10/11/99, and 10/19/99. Documentation is attached.

Appendix B (No. 16 – Halifax). Physical Therapy Visit Report has been provided for date of service 1/10/00. Documentation is attached

Appendix B (No. 22 – McDowell) A Daily Activity Record for Occupational Therapy has been provided for date of service 8/26/99. Documentation is attached

Appendix B (No. 24 – Union). Therapist has reported that the therapy room had to be cleared due to molds. The records were discarded.

Appendix B (No. 27 – Union) Union County provided the Occupational Therapy Annual Treatment Log that reflects services were provided on 1/4/00 along with a sample of the work prepared by the student on 1/11/00. Documentation is attached.

Appendix B (No. 29 – Forsyth) According to Forsyth County, it was stated during the audit that the therapy notes were destroyed in a fire and are therefore not available.

Appendix B (No. 36 – Forsyth) Forsyth County provided clinician notes for the following dates of service: 10/14/99 and 10/21/99. Documentation attached.

Appendix B (No. 61 – Jackson) Jackson County provided Occupational Therapy progress notes and monthly activity record for February 2000. Documentation is attached.

Appendix B (No. 68 – Wake) Wake County provided documentation from the daily speech log for the month of April 1998. Documentation attached.

Appendix B (No. 73 –Wake) Wake County provided clinician notes for the following dates of service: 4/13/99 and 4/21/99. It appears there was a clerical error as to date on the scanner form since the date marked on the scanner form was 4/14/99 rather than 4/13/99.

Appendix B (No. 78 – Wake) Wake County provided documentation from the daily speech log for the month of September 1999. Documentation attached.

Schedule 1

Appendix B (No. 79 – Wake) Wake County provided documentation from the speech /language therapy notes reflecting treatment for the month of October 1999. Documentation attached.

Appendix B (No. 136 – Henderson) Henderson County provided Physical Therapy treatment notes for the 1996/1997 school year. Documentation is attached.

Appendix B (No. 184 – Vance) Vance County provided clinician notes for the following dates of service: 2/3/98, 2/10/98, 2/19/98, and 2/26/98. Documentation attached.

Claim Missing - Attribute 2

Appendix B (No. 44 – Iredell) The billing provider has supplied a copy of the billing claim for date of service 9/14/99. Documentation attached.

Appendix B (No. 45 – Iredell) The billing provider has supplied a copy of the billing claim for date of service 2/7/00. Documentation attached.

Appendix B (No. 136 – Henderson) The billing provider has supplied a copy of the billing records for the date of service April 1997. Documentation attached.

Attribute 3 - IEP Missing

Appendix B (No. 37 – Forsyth) According to Forsyth County, this is a situation where the parent regularly refuses to sign the IEP. The County operates under the previous IEP until such time as a new IEP has been signed by the parent. In this specific case, the IPE was signed 2/00. Documentation attached including the preceding and post IEP.

Appendix B (No. 190 – Edgecombe) The LEA provided a copy of the IEP that was in effect for the time period audited, September 1998. The IEP covers the period 3/18/98 through 3/17/99. Documentation attached.

Attribute 4 -Assessment Results Missing

See response narrative.

Attribute 5 - Services Rendered Prior to Date of Authorization

See response narrative.

Schedule 1

Attribute 6 - Physician Authorization missing

Appendix B (No. 136 – Henderson) The billing provider has supplied a copy of the physician authorization for the service month of April 1997, school year 1996/1997. Documentation attached.

Appendix B (No. 137 – Henderson) The billing provider has supplied a copy of the physician authorization for the service month of November 1998, school year 1998/1999. The authorization reflects the year 1998, which represents the 1998/1999 year.

Appendix B (No. 157 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of December 1997, school year 1997/1998. Documentation attached.

Appendix B (No. 158 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of February 1998, school year 1997/1998. Documentation attached.

Attribute 7 - Physician Authorization Does Not Match Service Date

See response narrative and the following documentation:

Appendix B (No. 46 – Durham) The billing provider has supplied a copy of the physician authorization for the service month of January 1997, school year 1996/1997. Documentation attached.

Appendix B (No. 47 – Durham) The billing provider has supplied a copy of the physician authorization for the service month of February 1997, school year 1996/1997. Documentation attached.

Appendix B (No. 48 – Durham) The billing provider has supplied a copy of the physician authorization for the service month of March 1997, school year 1996/1997. Documentation attached.

Appendix B (No. 49 – Durham). Durham County provided a copy of the physician authorization that was provided to the auditor at the time of the audit. The school year reflected on the authorization reflects 1998, which represents the 1998/1999 school year. This authorization covers the service period, January 1999. The cost should not be disallowed based solely on audit interpretation.

Appendix B (No. 70 – Wake) See Explanation for No. 49 – Durham

Schedule 1

Appendix B. (No. 71 – Wake) See Explanation for No. 49 - Durham

Appendix B (No. 72 – Wake) See Explanation for No. 49 – Durham

Appendix B (No. 73 – Wake) See Explanation for No. 49 – Durham

Appendix B (No. 75 – Wake) See Explanation for No. 49 – Durham

Appendix B (No. 76 – Wake) See Explanation for No. 49 - Durham

Appendix B (No. 96 – Charlotte-Mecklenburg) The billing provider has supplied a copy of the physician authorization for the service month of June 1998, school year 1997/1998. Documentation attached.

Appendix B (No. 114 – Charlotte-Mecklenburg) The authorization on file reflects the school year 1998 which represents the 1998/1999 school year. The date of service is February 1999, which is covered by the authorization on file.

Appendix B (No. 150 – Cabarrus) The billing provider supplied a copy of the physician authorization for the service month of January 1999, school year 1998/1999. Documentation attached.

Appendix B (No. 154 – Gaston) The billing provider supplied a copy of the physician authorization for the service month of December 1998, school year 1998/1999. Documentation attached.

Appendix B (No. 155 – Buncombe) The billing provider supplied a copy of the physician authorization for the service month of February 1997, school year 1996/1997. Documentation attached.

Appendix B (No. 156 – Buncombe) The billing provider supplied a copy of the physician authorization for the service month of December 1997, school year 1997/1998. Documentation attached.

Appendix B (No. 159 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of March 1998, school year 1997/1998. Documentation attached.

Appendix B (No. 161 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of April 1998, school year 1997/1998. Documentation attached.

Appendix B (No. 162 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of May 1998, school year 1997/1998. Documentation attached.

Appendix B (No. 164 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of May 1998, school year 1997/1998. Documentation attached.

Appendix B (No. 165 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of December 1998, school year 1998/1999. Documentation attached.

Appendix B (No. 168 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of February 1999, school year 1998/1999. Documentation attached.

Appendix B (No. 171 – Buncombe) The billing provider has supplied a copy of the physician authorization for the service month of April 1999, school year 1998/1999. Documentation attached.

Appendix B (No. 173 – Buncombe) The authorization on file reflects the school year 1998 which represents the 1998/1999 school year. The date of service is May 1999, which is covered by the authorization on file.

Appendix B (No. 174 – Buncombe) The authorization on file reflects the school year 1998 which represents the 1998/1999 school year. The date of service is May 1999, which is covered by the authorization on file.

Appendix B (No. 191 – Person The billing provider has supplied a copy of the physician authorization for the service month of October 1998, school year 1998/1999. Documentation attached.

Attribute 8 - Authorization Not Dated

See response narrative on authorizations.

Appendix B (No. 1 – Rockingham) The form was already dated by another signatory. The physician has now supplied his own date and initialed it on the attached form.

Attribute 9 – Provider Qualifications Not Met

Appendix B (No. 35 – Forsyth) According to information provided by Forsyth County, the therapist in question worked under the supervision of the Lead Speech Language Pathologist during the time period audited.

The following attachments were inadvertently omitted from the original package, **Schedule 1**:

Attribute 2 – Claim Missing

Appendix B (No. 28 – Forsyth) The billing provider has supplied a copy of the billing claim for the date of service 1/31/97. Documentation attached.

Appendix B (No. 29 – Forsyth) The billing provider has supplied a copy of the billing claim for dates of service: 2/3/97, 2/7/97, 2/10/97, 2/19/97, 2/24/97. Documentation attached.

Appendix B (No. 30 - Forsyth) The billing provider has supplied a copy of the billing claim for dates of service during the month of April 1999. Documentation attached.

Appendix B (No. 31 - Forsyth) The billing provider has supplied a copy of the billing claim for 5/4/99 and 5/5/99. Documentation attached.

Attribute 6 – Physician Authorization Missing

Appendix B (No. 30 – Forsyth) The billing provider has supplied a copy of the physician authorization for speech, PT and OT for the 1998/1999 school year. Documentation attached.

Appendix B (No. 31 – Forsyth) The billing provider has supplied a copy of the physician authorization for the 1998/1999 school year. Documentation attached.

Appendix B (No. 32 – Forsyth) The billing provider has supplied a copy of the physician authorization for the 1998/1999 school year. Documentation attached.